FORM APPROVED

Division of Health Care Facilities				*	FORM APPROVE			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4502			(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 01 - MAIN BUILDING 01	COMPI	(X3) DATE SURVEY COMPLETED		
NAME OF DOOLARS OF ALL				DDRESS, CITY, STATE, ZIP CODE			2/06/2011	
	SON COUNTY NURS	no de la constitución de la properción de la constitución de la consti	914 INDU DANDRID	ISTRIAL PARK OGE, TN 37725	RD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOLLD BE	(X5) COMPLETE DATE	
	During the Life Safety portion of the survey conducted on December 6, 2011, no licensure deficiencies were cited under chapter 1200-8-6,			N 002				
	Standards for Nurs	ing Homes.	200-0-0,					
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9	ε							
on of Healt	h Care Facilities R	oga L. Myn	11		TITLE		(6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

Division of Health Care Facilities

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4502		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - 916 INDUSTRIAL PARK - ( B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF BUILDING			10000		12/0	06/2011		
JEFFERSON COUNTY NURSING HOME 914 INDU-				DRESS, CITY, STATE, ZIP CODE STRIAL PARK RD DGE, TN 37725				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	III D RE	(X5) COMPLETE DATE	
N 002	2 1200-8-6 No Deficiencies			N 002				
	During the Life Safe were no deficiencies Standards for Nursi	s cited from 1200-8-6	rey, there					
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vision of Hea	ilth Care Facilities 7	ga L. Morro	£ŧ		TITLE ,	1	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

Division of Health Care Facilities

T-480 P0022/0026 F-863

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER  TNATES		ER/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 03 - 918 INDUSTRIAL PARK B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET AN				180000 <u>1</u> 0-0-0-0	12/06/2011	
JEFFER:	SON COUNTY NURS	ING HOME	914 INDUS DANDRIDG	RESS, CITY, STATE TRIAL PARK I E, TN 37725		
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR L	- I I I I I I I I I I I I I I I I I I I		IIDRE COMPLETE		
N 002	During the Life Safe	ety portion of the suns	(e), there	N 002	DEFICIENCY)	
ision of Heal	th Care Facilities	) ,a /				
SORATORY D	IRECTOR'S OR PROVIDE	ogn L. Myno	TT.		TITLE	(X6) DATE

Administrator

12/20/11

FORM APPROVED

Division	of Health Care Fac	ilities				FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4502		ER/CLIA IMBER:	(X2) MULTIP A. BUILDING B. WING			LETED	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE 12/06/2011			
	SON COUNTY NURS	15 NEW	914 INDUS DANDRIDG	TRIAL PARI E, TN 3772	KRD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiency During the Life Safe were no deficiencie Standards for Nursi	ety portion of the suns cited from 1200-8-	vey, there	N 002	DEFICIENCY)		
rision of Heal	Ith Care Facilities	an L. Ma	//				
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE